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For information about articles or advertising in the Texas Psychologist, please contact Lauren Witt at (888) 872-3435 or tpa_lwitt@att.net
Psychology is about change, right? Good thing we all know how to embrace changes because they are everywhere bubbling up in our professional lives. This issue of the *Texas Psychologist* provides updates about several areas where things are changing. The health care marketplace will undergo big changes in the near future. Dr. Rick McGraw offers a succinct explanation of some of the ways this may affect many of us and makes suggestions about how we should be thinking about this. Delivery systems are undergoing rapid changes as health care catches up to the digital age. Chang, Frazier, and Elliott describe a cutting edge demonstration of how teletherapy might work (and they have preliminary data to back it up). Training models are changing too, and bringing services to places where they have been in short supply. Dr. Joseph McCoy details the growth of the Lone Stare Psychology Residency Consortium, a project that TPA helped launch. Even the rules of practice are in flux—see Dr. Floyd Jennings’ discussion of the regulations regarding patient records. Of course the DSM is changing, and this issue of the *Texas Psychologist* provides an introduction to what these changes might mean.

TPA itself is changing. Our President-Elect, Dr. Marcy Laviage recently attended the State Leadership Conference in Washington. This is an annual gathering of psychologists from across the country who come together to lobby for psychology in Congress. Akin to TPA’s own legislative day, it represents a major arm of policy influence on behalf of the profession. This is especially important for the early and mid-career psychologists whose futures will be defined by policies made today. As Marcy notes, the demographics of our field are shifting rapidly, and if we are to be well represented in these forums we will need to accommodate the fact that many people who would or should be participating are women who are juggling families.

While Marcy reports on the many issues that are looming at the federal level, in his presidential column, Dr. Ray Brown reviews the activities of TPA on your behalf during this busy legislative session.

As Ray notes, we face many challenges. TPA is the only place where your professional interests are represented. You can support TPA by asking a colleague to join, by becoming a Platinum Advocate Member, and by volunteering for a committee. Embrace the challenge!

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As I prepare this article, I find myself literally immersed in the fabric of what our organization, the Texas Psychological Association (TPA), is all about. I am, once again, speaking of the protection and the enhancement of our profession, a profession that is under attack and experiencing never-ending risk. Our primary mode of defense is through the legislative process and TPA, at this very moment, is actively involved in the 83rd Texas Regular Legislative Session. We are working daily for the passage of bills that we have introduced; we are supporting the bills proposed by others that have a positive impact on psychology and/or on the public; and we are speaking up in an effort to kill bills that are not good for psychology. I sincerely believe that with the remarkable efforts of our Executive Director, David White, and his never-ending presence at the Capitol during the session (along with able consultation from our legislative consultant, Shannon Noble) things are happening! TPA is making its presence known and David is being regularly sought out for input, suggestions and questions about where psychology stands on legislative matters of concern. The Legislative Committee members have worked tirelessly and have met weekly since before the session began. Each of us, as TPA members, need to be part of this as well, and this means being ready to respond when you receive a call from a Grassroots Committee member who is making a request for action. Currently, we have two House Bills (807 and 808) that, with sound lobbying and committee testimony, have already moved through house hearings. The former bill is designed to further protect the use of the term psychology or psychologist in a job title. The latter bill is designed to allow for provisionally licensed psychologists and newly licensed psychologists to accelerate their movement into the workplace through the assurance that their services can be billed to and paid by insurance companies. We also are working on a bill that, if we are successful, will strengthen the role of psychology in conducting and signing off on guardianship evaluations for the courts.

The brief legislative update above only touches the surface of what the leaders of TPA are doing right now, not just for you, the members of the TPA, but for every licensed psychologist and every doctoral student of psychology in Texas. I can assure you that, without TPA, little or none of this would be happening, and psychology would be under even greater and more damaging attack than we are experiencing today. You see, and I make my familiar point yet again, TPA is the only organization in Texas that is responsible for the protection of our very being. That truly makes me wonder, particularly in these difficult times, why any psychologist in the state of Texas would not be a member of this great organization.

Recent articles abound that address the concerns I have stated regarding the welfare of psychology, the future of psychology, and the need to protect the profession. Nicholas Cummings, PhD, and former president of APA, recently published an article in The National Psychologist that bore the title of, “The short, unhappy life of clinical psychology: R.I.P.” a title that was extracted from an article by George Albee from back in 1970. Dr. Cummings spoke of how psychology averted an untimely death
in past decades. At the same time, however, he spoke of the concerns and the pessimism that abound when our profession is discussed, and he touched briefly on the looming demise of the doctoral standard by stating his belief that some 80% of all psychotherapy is being conducted by non-doctoral individuals. He stated rather bluntly that, “The American public sees no advantage in our doctorate, and we have failed to persuade them otherwise…” He addressed the need for even those who teach psychology and who also heavily populate organizations such as APA, to mobilize and get on board in supporting the doctoral standard and the profession of psychology, as otherwise, the demise of the academic programs of psychology are also at risk. His appeal was indeed to the academic psychologist, and he stated that, “Yes, our fate rests with the dubious ability to mobilize our detached clinical colleagues in academia.” Certainly, the point made by Dr. Cummings is well taken, but those of us who are in the applied areas of psychology need also to step up and take protective responsibility of our profession. The mobilization needed for this in the state of Texas is available only through TPA!

Along the same lines, Robert H. Woody, Ph.D., writing recently in the Independent Practitioner, spoke to the heart of our need to mobilize as a profession if we are to survive. The fitting title of his article was, “Professionalism Mandates Affiliation: We Need Psychological Associations More Than Ever!” He speaks of the Medicare debacle and the increasingly politicized aspects of our health care and the financial impact on psychologists because of this. In Texas, TPA has responded to this very issue through our Business of Practice Committee, which is made up of some of the most committed and hard-working individuals among TPA members. This group has effectively salvaged some of the financial cuts that we were facing and those efforts are ongoing. Dr. Woody spoke of the “laments from psychologists who complain that their incomes have decreased dramatically,” and we certainly understand that. He spoke of how some practitioners are choosing to leave the field or leave their practices to take salaried positions. We at TPA are working diligently to safeguard, wherever possible, both our profession and those individuals whom we serve. We also are encouraging, as you will see in the title and scope of our next convention, that we are strongly supporting the exploration of new methods of delivery and new areas of service delivery for our profession. Dr. Woody spoke with alarm and concern that psychologists are tending, very naïvely and unwisely to drop association memberships as a means of saving money and reducing the impact on their dwindling incomes. He quoted one source, indicating that for every new member that professional organizations were gaining, two members were dropping out. He also reported another statement that summarized the sentiments of many polled APA members, that is that, “I have to drop out of professional associations because I do not have much disposable money—I have to give priority to paying the bills to support my family and keeping my office going.” I, like Dr. Woody, loudly proclaim to you that this is the time that psychological associations are most needed, a time in which we need, through these associations, to regain the authority over psychology and neither go with the “flow” nor think that we can save enough money from not paying association dues to make a difference. Only through a joint effort will the obstacles before us result in any significant level of success. It is our collective responsibility to protect the professional status of our great profession, psychology. I echo the statement by Dr. Woody that, “...I assert that every psychologist should IMMEDIATELY give priority to maintaining affiliation with an increased personal commitment (including financially) to professional psychology associations, both with APA and, among other options, the psychologist’s state psychological association.”

I have said in recent communications, and now repeat once again, that I do not choose to be totally pessimistic regarding the grand profession of psychology. My passion for this chosen field is as great today as it ever was—even in the sunset years of my personal career. If we are to preserve it for the next generations, however, we must learn how to confront change rather than running from it. We must band together through professional associations (and right now I am talking about the Texas Psychological Association) if we truly wish to leave a viable profession behind for those who follow. Change is always difficult and what we are dealing with is no exception. The changes involving governmental control, managed care, eroding compensation, and micromanagement are distasteful, particularly to those of us who knew nothing of such in our early careers. Our plight mirrors that story that we all heard in childhood wherein the weakness of a straw or a twig was demonstrated through how it could be easily snapped in two. However, when bundled altogether, strength was found and breaking the greater body in two was quite difficult. The mission of the Texas Psychological Association, at least as I understand it, is to represent and enhance the profession of psychology in Texas. Its purpose is to advance psychology as a science, as a profession, and as a means of promoting human welfare, and we believe that psychology is a doctoral-level profession. Fighting for that is what TPA can and will do for each of us. It is what TPA is doing during this legislative session.

Once again, I challenge you to renew and invigorate your commitment to TPA, and I strongly urge you to make a personal mission to recruit no less than one new member this year. Our strength is in our numbers, and our profession is worthy of no less than our full commitment, protection and enhancement.
The ongoing evolution of Accountable Care is an enormous opportunity with many institutional providers having invested millions of dollars in becoming, incentivizing, supporting and transforming Accountable Care Organizations (ACOs). The ACO movement has the confidence of sophisticated players across the health care system. These groups understand that value-based quality care is the standard of the future. Psychologists cannot afford any degree of exclusion from this process.

What is an ACO? An ACO is a legal entity comprised of groups of providers that are willing to become accountable for quality, cost and overall care for designated populations. The minimum number of patient lives required for a health care organization to qualify as an ACO is five thousand. Hospitals and other organizations are currently buying physician practices in order to accumulate the patient base to form an ACO.

Unlike the last generation of managed care, the Patient-Centered Medical Home (PCMH) is the core of an ACO. A PCMH is an individualized primary care model with integrated specialists (including behavioral health) that are supported by hospitals and other parts of the delivery system, e.g., pharmacies. Many consider ACOs a viable vehicle for changing incentives in our health care system so that we move away from a sick care system where money primarily flows after an individual gets sick and towards a true health care system that focuses on primary prevention. The potential for cost savings and optimal utilization of limited health care resources is enormous.

Currently every state but Delaware has at least one ACO with Texas having the second greatest overall number at twelve. According to the American Hospital Association, there are 428 ACOs in the U.S. as of January 10, 2013. In Texas, ACOs exist in the Dallas-Ft. Worth, Amarillo, Wichita Falls, Austin-Central Texas, Houston, San Antonio, and Rio Grande Valley areas. Some of these areas have more than one ACO, and at one, Scott and White Healthcare-Walgreens Well Network LLC, is a consortium of medical providers/hospitals and a retail pharmaceutical organization.

Of the total number of current ACOs, there are more private ACOs than Medicare ACOs. The primary difference between private and Medicare ACOs is payment models. Private ACOs have a wider range of payment structures, e.g., full or partial capitation, bundled payments, retainer agreements, subsidies, and pay-for-performance incentives. Medicare has its own performance and quality incentive system. It is anticipated that those ACOs that are hybrids, with both private and Medicare components, will gradually shift to the Medicare payment structure to increase efficiency and associated cost savings.

What’s a psychologist to do? If you are nearing retirement, perhaps you should do nothing. The current fee-for-service system, even within Medicare, will continue to co-exist for at least some time. However, if you are mid- or early-career, you can anticipate competition from the cost and quality focused (with data to support) ACOs that will be increasingly attractive to health care consumers, both individual and organizational. Most rural providers and those with highly specialized practices will enjoy some isolation from these dynamics, as will those whose practices are primarily or entirely private pay.

But if psychology is to continue to serve the majority of the general population, we will likely find that the health care of a great many of those individuals will be coordinated by ACOs. The good news is that there will likely be a number of ways to participate in this evolving system in terms of structure and degree. Some of our options include: doing nothing and hope ACOs ignore the populations we serve, becoming preferred providers of an ACO, becoming members of an ACO, becoming founders/owners of an ACO, and becoming acquisition targets for an ACO.

One challenge in Texas to psychologists forming professional integrated health care entities is the prohibition of the corporate practice of medicine. A psychologist in Texas can form a legal entity with any other mental health professional except a physician. This is a clear limitation to psychology taking a broad leadership role in ACOs and something for us to consider addressing.

What is being done to facilitate psychology’s participation in the evolving ACO arena? The APA Practice Organization has developed resources for helping states prepare for the new health care environment. The American Psychological Association has established a Center for Psychology and Health in order to prepare and encourage more psychologists to assume roles in the broader health care system, to engage in activities associated with these roles, and to work in integrated health care settings. The Texas Psychological Association has established an Integrated Health Care Task Force to
SLC, CSL, STPA, APA, APAPO, CAPP, CESPPA not to mention ACO, RVU, GPCI, SGR, CBO, EHR…between March 8 – March 12, 2013, my head was a swirling bowl of alphabet soup. Take a bite and spit something out and the letters will inevitable mean something, but remembering what exactly meant I had a lot of learning to do. During this time, I had the pleasure and honor of attending the State Leadership Conference in Washington, D.C. sponsored by the APA Practice Directorate. This conference is for Presidents, President-Elects, Diversity Delegates, Federal Advocacy Coordinators, Public Education Campaign Coordinators, and Early Career Psychologists from each State, Provincial, and Territorial Psychological Association (SPTA); therefore, I was able to attend this esteemed group in my role as your President-Elect for TPA (aha! An acronym that needs no introduction!).

Let me first put out there that those of you who are parents of school-aged children will quickly recognize that these dates corresponded with Spring Break. My initial thought was, of course, that my two elementary-aged boys would travel with me to D.C. and learn about the colorful history of our government, while I learned about the colorful climate of our pending health care reform. But, then, I received the agenda for the five days and realized that while they would see really cool sights, and I would see really cool people, we would never actually see each other! So, a choice had to be made, an explanation provided to the boys, and an equally cool alternative offered to them while I would be away. Even at their young ages, not only did they understand, but my older one planned our remaining days of Spring Break together down to the minute, and my younger one sent me off saying, “Go make some new laws!” Ok, so maybe he didn’t quite grasp the concept that lobbying on Capitol Hill didn’t quite mean making new laws, but his enthusiasm was still much appreciated! As another colleague whom I met in D.C. confirmed, while it is hard leaving our children, not only do we believe in the work we are doing but the positive influence on our children is palatable. Her young daughter’s departing words to her before she hopped on a plane from North Carolina to D.C. was “Go change the world, Mommy!” Yes, we both teared up a bit as we bonded over the tug between professional and personal lives, but knowing our children see us as strong (stronger than we really are), powerful (more powerful than we really are), and influential (more influential than we really are) is a beautiful thing. I want to make sure I describe this vividly as I know the face of not just APA and TPA, but of psychology is changing as more and more women and parents join our awesome career. I want to shout from the rooftops, “You can do it!” “I can do it. You can do it. We can do it. We all NEED to do it. Ok, off the soapbox and back to reporting from SLC…

Finally, if you are not a member of both TPA and APA, please consider such a minimal contribution in your future and the future of the science and practice of psychology. If you are already a member, consider contacting TPA and volunteering some of your time to promote our profession and making it thrive in this transitional time.

A Report from the State Leadership Conference in Washington, D.C.

Marcy Laviage, PhD
TPA President-Elect
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Elects began working Friday night. I felt like I was in a Mrs. America pageant and should be wearing a state sash across the front of my body as I met Syd from Utah, Michele from Montana, Eleanor from Oregon, Lisa from Rhode Island, Melanie from Nevada, Jeff from Jersey as one by one we introduced ourselves and traded superficial talk about the weather, kids, and travel plans over dinner. Bright and early the next morning, we gathered again to learn about the Committee of State Leaders (CSL), the Council of Executives of State & Provincial Psychological Associations (CESPPA), and the Committee for the Advancement of Professional Practice (CAPP), and to have break out discussions on issues related to association management, member recruitment, and advocacy issues. By noon, I was already tired, but shocked into reality when I walked into the ballroom for the 1 p.m. official start to the conference to hear loud dance music and view a sea of round tables with state signs in the middle of them directing us to sit with our state delegation. I don't know why the party-like atmosphere surprised me so much, but it definitely set the tone of all being present for the same cause – to assure our profession obtains a seat at the health care round table!

After brief introductions by impressive individuals such as the Assistant Executive Director of APA Practice Directorate (who I also used to babysit for during graduate school in Connecticut – talk about a reunion!) and the chairs of CSL, CESPPA, and CAPP, we were treated to an inspirational introduction by Katherine Nordal, PhD, whom you all know to be Executive Director of the Practice Directorate (APADO). She set the stage by capturing what’s at stake for professional psychology and illuminated how national and state leaders are collaborating on behalf of practitioners and those who need psychological services. Then, my brain really had to kick into high gear as Mark McLellan, MPA, MD, PhD, took to the stage. As Senior Fellow, Director of the Engleberg Center for Health Care Reform, Dr. McLellan offered his perspective on how services under Medicare and Medicaid and in the private sector are likely to evolve under the Affordable Care Act. Every psychologist is faced with considering how fee-for-service models will survive, what role will guidelines and quality outcome measures play in our services, and more importantly how might psychologists position ourselves as critically important doctoral-level health care professional in the context of Health Insurance Exchanges and Accountable Care Organizations. No one, not even the incredibly impressively brilliant Dr. McLellan, had the answers; however, everyone was motivated to make sure we are poised to take on whatever the future holds.

After this mind-draining presentation, I followed it up by more networking with my fellow President-Elects and by now, conversations had moved from superficial to more intriguing specifics of how psychology was being managed in each of our states. With my colleague and Diversity Delegation representative from Texas, Dr. Greg Simonsen, I then went back into the ballroom to witness what I kept hearing as “the inner-workings of politics, we were on our own to decide if we wanted to learn more about Changes in Medicare’s PQRS Reporting Program, Psychology’s Coverage in the News, New Clinical Practice Guidelines Put Out by APA, How to Use CAPWIZ – an online service to mobilize an SPTA for state-level advocacy, Navigating Electronic Health Records, or Exploring New Practice Models in the Coming of Health Care Reform. I chose the latter and learned how important integrated health care practices will be in the age of the Affordable Care Act (ACA).

The remaining afternoon, after another awards luncheon with more remarkable speakers and inspirational individuals, was spent being briefed on the issues we would be bringing to Capitol Hill on Tuesday. Learning about the issues as well as how to effectively meet with our legislators was conducted via presentations, reading materials, and rehearsals, assuring we would all be prepared to march on the Hill and make our presence known.

While Sunday was focused on national issues related to health care and lobbying efforts, I tried to focus Monday on state issues. After learning about APA’s Good Governance Project, I have to say, I was proud to recognize that TPA does a lot of things really well. Of course there can be improvements – and there will be – but we do it right much of the time. And while I could have attended seminars on the new CPT codes, diversity leadership, integrated care in hospitals and health systems, or federal advocacy, I chose what I felt was the most important reason for being at the conference in the first place – KEEPING YOUR SPTA LIVELY: BOARD ACCOUNTABILITY AND MEMBER ENGAGEMENT. Bingo! Now, that is what I wanted to talk about, hear about, and learn about! Be forewarned TPA members – I am coming to get you engaged; there is no place to hide!

Again, as I participated (and for those of you who know me, I am not a quiet participant) in the workshop, I found myself thinking how well we actually do things in TPA. Yes, this is in comparison to other state associations who, like us, have their struggles, but we are quite creative in our member recruitment. Take our new Platinum Advocate Membership – other association leaders were so intrigued with this idea! They couldn’t believe we pulled it off so successfully in our any way replicate this award ceremony at our own TPA annual convention, it would be awesome! Don’t think I am not going to try! So, please keep your eye out for nominations for Psychologically Healthy Workplaces in Texas because it would be so cool to capture this aspect of psychology and how it impacts regular people on a daily basis.

The next two days were again filled with dense material beginning Sunday morning with a special inside look of politics by Senior Correspondent of PBS NewsHour and former CNN anchor, Judy Woodruff. She was bleary-eyed after spending the night before at the annual Gridiron Dinner where President Obama addressed the group of press and politicians. She described the current climate in Washington, how it has changed over time, and what to expect in the near future.

Once we were all awake from her often humorous depictions of the inner-workings of politics, we were on our own to decide if we wanted to learn more about Changes in Medicare’s PQRS Reporting Program, Psychology’s Coverage in the News, New Clinical Practice Guidelines Put Out by APA, How to Use CAPWIZ – an online service to mobilize an SPTA for state-level advocacy, Navigating Electronic Health Records, or Exploring New Practice Models in the Coming of Health Care Reform. I chose the latter and learned how important integrated health care practices will be in the age of the Affordable Care Act (ACA).

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first year! I also have to admit, I walked out of there with a bit of a smirk on my face. I already mentioned earlier that my role as President-Elect has been a bit unusual because I have two young children, a full-time practice and am under the age of 40 (ok, for one more month anyway!). I have been known to mention every now and then of 40 (officially sponsored “family” trip, and it’s hard to have a board meeting scheduled on Halloween Night (ok, that was officially my last time commenting on this one – I am over it), but I would also like to say that I do recognize that psychologists remain a very diverse group in age, gender, income, interests, and many other factors. I fully respect and want to attend to the needs of everyone. However, in this workshop, the main focus was on how to engage the younger, early-career psychologists. With ideas thrown out like having nursing stations for new mothers at conferences and babysitting for board meetings, I embraced the notion that I am not in fact being subjective or selfish, but that these are the kinds of ideas that we need to consider in order to continue to thrive as an association. I want to make sure that everyone feels represented by TPA, and I want to make sure that TPA is set for the future. I walked away with many new ideas and I implore each of you to contact me with any other ideas on how to recruit and engage members in TPA – a state association that I can truly say is open to innovation and a leader among other associations in advancing psychology and meeting the needs of psychologists.

The final day of SLC was our day on Capitol Hill. We were too busy inside Friday, Saturday, Sunday, and Monday to notice, but I heard that the weather in Washington, D.C. was beautiful. Unfortunately, this was not the case on Tuesday. Rain greeted us in the early morning, and I quickly learned that the House buildings and the Senate buildings are about as far apart as Democrats and Republicans on budget issues. We were wet, and I’m sure I made quite the professional impression on one of our brilliant student representatives as I attempted to dry my hair under the hand dryer in the bathroom of the Hart Senate Building before meeting with an aide from Senator Cornyn’s office. Your esteemed Federal Advocacy Coordinators for Texas, Dr. Cheryl Hall and Dr. Dean Parèt, created a “divide and conquer” plan as we split into group to meet with as many Texas legislators as possible. I first paired up with Dr. Dean Parèt to meet with Representative Hall’s office after a quick stop into Representative Poe’s office. We then traipsed across the wet path in front of the stoic Capitol to Senator Cornyn’s office before meeting for lunch and then heading back to the other side to meet with Representative Johnson’s office. The issues being discussed with our legislators were as follows:

- Medicare reimbursement - As you know, in late December Congress passed legislation to delay a 26.5% cut in all Part B reimbursements. This was the 15th time Congress has acted to stop a Sustainable Growth Rate (SGR) cut. SGR is only one of the threats to psychologists’ reimbursement rates in the program. Sequestration and flaws in the underlying payment formula are also lowering payment rates. We detailed these issues and explained how Congress needs to act now.
- Medicare Definition of physician – We raised the need to add psychologists to the Medicare definition of physician, in order to remove an unnecessary layer of physician supervision. We are the only doctoral-level profession not included.
- Health information technology – We were seeking cosponsors of bills that would make psychologists eligible for Medicare and Medicaid financial incentives to adopt electronic health records. We are being encouraged to join the electronic health records momentum but not receiving funds to make the transition that is being offered to physicians.

While our Texas legislators were open to discussing these issues, the real impact was felt when all delegates convened at a nearby church to process the events of the day before heading to the airport. Delegates from Georgia, Connecticut, Rhode Island and others were successful at not just solidifying support for these bills, but securing sponsorship as well. It was a tremendous lesson in the power of numbers and the power of invested psychologists.

And, it was the perfect way to end my first State Leadership Conference. It was exactly how John Quincy Adams exhorted: If your actions inspire others to dream more, learn more, do more and become more, you are a leader. I was inspired by the leaders in our field, and I hope I can inspire you to work for this extraordinary profession we all share.

To close, I want to acknowledge and thank the participation of the following TPA delegates at SLC. If you see them, please thank them for all of their hard work and effort on behalf of TPA and all psychologists!

David White – Executive Director
Lauren Witt – Director of Marketing and Public Relations;
THE go-to person for all of us in D.C.!
Dr. Greg Simonsen – Diversity Delegate
Dr. Cheryl Hall – Federal Advocacy Coordinator
Dr. Dean Parèt – Federal Advocacy Coordinator
Dr. Kay Allensworth – Public Education Campaign Coordinator
Dr. Rick McGraw – APA Council of Representative
Katherine Ramos – APAGS, State Advocacy Coordinator
Dr. Alice Holland – APAGS, Regional Advocacy Coordinator, Southwest
Emily Voelkel – APAGS, Regional Advocacy Coordinator, Northwest

If you have any thoughts, suggestions, or feedback of any kind, please feel free to contact me at marcyliaviage@gmail.com.
Using Videoconferencing to Provide Psychological Services to a Rural Clinic: A Unique Town and Gown Partnership

Jessica E. Chang, MEd
Chantel G. Frazier, MS Ed
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An estimated 20% (55 million people) of the total United States population live in rural areas and are faced with the barriers of low accessibility, availability, and acceptability of mental health services (Health Resources and Services Administration, 2005). These barriers include a shortage of capable health providers and access and availability to treatment. Mental health services in rural areas usually lack coordination and consistency, and access and availability to mental health services is hindered by high rates of poverty, transportation, low health insurance, and poor health. An estimated one-third of rural counties in the United States lack any health professionals equipped to address mental health issues, with a much larger ratio of rural counties lacking any kind of specialty mental health services (Gamm, Stone, & Pittman, 2003).

Texas has one of the largest rural-residing populations in the United States. It also has the highest proportion of counties designated as mental health provider shortage areas in the United States (Trust for America’s Health, 2013). As in other states, mental health services in Texas largely remain concentrated in more populous areas where need and resources are also concentrated. Without aggressive training, preparation and the implementation of innovative service provision strategies, rural Texas will only experience further declines in the number of mental health providers available to provide services to those tens of thousands of rural citizens in need of care (The Hogg Foundation for Mental Health, 2007). Despite the concerted efforts by groups such as the Lone Star Psychology Residency Consortium, it is unlikely that these complex issues will be fully resolved by increasing the number of available mental health service providers. Without significant changes in national and state health policies and innovative reimbursement mechanisms, new providers will, like their colleagues, continue to concentrate in urban areas where they can be assured of a client base or join an ongoing practice and enjoy the amenities of contemporary urban life available to most professionals. However, solutions to address mental health disparities in rural areas may be addressed, in part, in the strategic application of new service delivery strategies with new communication technologies.

In this paper we present an innovative and unique “town-and-gown” partnership between the Center for Community Health Development and the APA-accredited Counseling Psychology doctoral program at Texas A&M University with community leaders in Leon County that provides a logical, cost-effective, empirically supported, and potentially sustainable option for providing mental health services to Leon County residents who otherwise have limited options for services. It also provides valuable training and research opportunities for Counseling Psychology doctoral students. The development of the partnership and initial evidence for its effectiveness are discussed in this paper.

Mental Health Disparities in the Brazos Valley
Five of the seven counties in the Brazos Valley — a region located in south-central Texas, approximately 90 miles northwest of Houston — have been designated as Mental Health Provider Shortage Areas (Health Resources and Services Administration, 2013; see Figure 1). Like their counterparts in other rural regions of Texas, residents of the Brazos Valley face health disparities resulting from geographic isolation, limited availability of services, lack of transportation, poor socioeconomic status, low educational achievement, lack of insurance, and a host of other contributing factors. To identify and understand the health disparities, and to find avenues by which community resources could be developed and coordinated to address these disparities, the Center for Community Health Development (CCHD; http://www.cchd.us/) at the Texas A&M University Health Sciences Center conducted a series of meetings with community leaders,
health care representatives, and concerned non-profit and advocacy groups. These stakeholders established the Brazos Valley Health Partnership in 2002 to collaboratively address health disparities in the region, and to explore and evaluate opportunities to build capacity to provide sustainable services. The CCHD also conducted a series of comprehensive health surveys of the Brazos Valley to inform policies and planning.

Leaders in Leon County were particularly active in this process. Leon County is a rural county in east Texas, covering 1,072 square miles, and is home to an estimated 16,344 residents. Centerville, the county seat, is almost equidistant from Houston and Dallas, and had a population of 977 at the 2010 census. The majority of the population resides in unincorporated areas. Positioned on the farthest edge of the Brazos Valley service region, the population in Leon County is dispersed throughout the county. Most area health care systems do not preserve an office or staff in the county. Leon County residents who want any type of health services typically travel at least an hour’s drive in one direction.

To address these needs, the Leon County Health Commission established the Leon Health Resource Center, a facility located centrally in Centerville to house a full-time community health clinic and provide space for other service providers to see local clients without incurring additional overhead. The county contributes the cost of utilities and an office manager to coordinate operations. The county also developed a free, volunteer-based transportation system for residents to get to health-related services.

We know from the extant literature that the prevalence of behavioral disorders and mental health problems are at least as high in rural areas as in metropolitan areas, but mental health issues in rural communities are exacerbated by the lack of mental health services and highly-trained mental health service providers. The 2006 Brazos Valley Health Status Assessment Report conducted by the CCHD identified health disparities for rural residents and access to mental health services as two of the top five priority areas for health planning and development in the region. Similarly, the 2010 survey revealed the following:

- Throughout the region 18.1% reported being diagnosed with depression, and 15.8% reported being diagnosed with anxiety.
- 41.7% reported at least one poor mental health day in the past month; 19.9% reported more than five poor mental health days.
- One in four (25.6%) who needed mental health services did not receive them — 41.7% in the counties other than Brazos County (where the population is much higher due to the presence of Texas A&M).
- Of those needing drug and alcohol abuse services, 51.9% did not receive those services.

The 2010 survey included a brief, criterion-referenced measure of depression, the Patient Health Questionnaire – 9 (Kroenke, Spitzer, & Williams, 2001). In a recent analysis of these data (from a total N = 3,965 respondents), 5.3% had minor depressive symptoms and 5.7% likely met criteria for a major depressive episode. The combined rate of “probable depression” is higher than the rates reported in other studies using similar measures with rural samples. Additionally, we found that women had the highest rates of depression, generally. Among the ethnic groups African-American respondents had the highest rates of depression (Brossart, Wendel, Cook, Castillo, Elliott, & Burdine, 2013). African-American women had the highest rates of depression among all respondents. These findings suggest that women and African Americans in this underserved and predominately rural area may face unique issues that compromise their emotional well-being and contribute to the development of depressive symptoms.

After considering the results of the 2006 health survey, the Leon County Health Resource Commission (LHRC) began meeting with local health care providers, the local United Way, various Texas A&M University faculty, and with the local health division of the state of mental health and mental retardation authority to recruit mental health service providers. The CCHD and LRCH identified a potential resource in the accredited doctoral program in Counseling Psychology at Texas A&M University. The program’s department operates a non-profit psychological services and training clinic—the Counseling and Assessment Clinic (CAC) – in a Federally Qualified Health Center (FQHC) in Bryan, Texas (about 70 miles from Leon County). Students in the Counseling Psychology doctoral program provide counseling and assessment services in the clinic under the supervision of program faculty, and they accrue practicum hours that count toward their degree and internship requirements.
Subsequently, the LHRC decided the CAC would be a logical, cost-effective, and potentially sustainable option for providing mental health services to residents in this rural community. To increase accessibility and availability to rural residents, the Commission then decided to establish a high-speed, T1 connection between the CAC and the rural health resource center in Leon County. Videoconferencing technology can effectively extend psychological services to rural areas, decrease travel burden, and keep individuals physically near their support systems in their home communities. With technical assistance from the CCHD, the Leon County Health Resource Commission secured a Rural Health Network Development grant from the Health and Resources Service Administration (HRSA).

The grant provided assistantships (for counseling psychology students), equipment, and initial infrastructure necessary for providing counseling services via videoconferencing capabilities to clients at the health resource center in compliance with the Health Insurance Portability and Accountability Act. Designated rooms at the CAC and at the Leon County Health Resource Center were equipped with a 42-inch, high-definition widescreen television and a standard PolyCom teleconferencing unit, including a high-definition camera and microphone. The equipment provides real-time audio and video communication on a high-speed and secure T1 Internet connection that permits “real time” therapeutic interaction between counselor and client. The internet connection is encrypted to comply with HIPPA regulations. The interaction between counseling and client is depicted in Figure 2.

The Clinical Protocol
Services from the CAC site to Leon County began in May 2009. A clinical protocol was established to parallel standard practice at the CAC “walk in” clinic. Clients at the Centerville clinic are self-referred, or referred by a local agency (e.g., the state Mental Health Mental Retardation authority), by one of the area health care providers, or by any of the non-profit or other community organizations (e.g., from a school, church). The Service Coordinator at the Leon County Health Resource Center (LHRC) gathers client information, briefly describes the process to the client, and lets the client know a counselor will speak with them soon. The Service Coordinator next contacts the “telehealth” counselor at the CAC to let them know a new client is on the waitlist. Once the basic information is given to the counselor, they then assign the client based on a counselor’s current client load as well as specific client needs. Currently, we have 7-10 counselors at various stages of their doctoral training.

We are fortunate to have bilingual students in the program so we are able to provide services in Spanish. It is vital to offer bilingual services in order to accommodate the ever-expanding Hispanic population in Texas.
procedures, and how clinic information will be used for archival research. It also provides the trainee’s supervisor’s information. The consent form that was completed before the session is reviewed again to reiterate the limits of confidentiality and to discuss any questions the client might have. Once the client has asked all their questions, a form entitled, “Notice of Policies and Practices to Protect the Privacy of Your Health Information” is provided and explained, in which clients learn how their information is treated according to HIPPA regulations. The client may request a copy to take home.

The counselor then conducts a structured therapeutic interview and administers a brief measure of mental status and a measure of current well being and functioning. Initially, a version of the SF-12 (an omnibus quality of life instrument; Ware, Kosinski, Turner-Bowker, & Gandek, 2002) was used for this purpose but we now use another measure developed for psychotherapy outcome research (the Clinical Outcomes in Routine Evaluation- Outcome Measure; CORE, 1998). The counselor attends to the client’s primary reason for seeking mental health services, family dynamics and relationship, spiritual or religious practices, history of abuse, and previous or current suicidal ideation. In addition, the counselor may ask any relevant follow up questions about the client’s answers on any of the measures.

Once the client and counselor feel that sufficient information has been gathered, the counselor schedules their next session and explains that the upcoming, and all future appointments, will be 50 minutes long, once a week, and will be more collaborative and less directive in nature.

Following the intake, the counselor writes their assessment of the content of the session, results from the assessment, therapeutic impressions, and a corresponding treatment plan. The Telehealth CAC staff utilizes Titanium Schedule, a HIPPA-compliant electronic records program specifically designed for university counseling centers to facilitate scheduling, storing of progress notes and assessment reports. The notes are then forwarded to the counselor’s supervisor to be approved. A member of the Counseling Psychology faculty provides weekly supervision for each counselor.

Clients are scheduled for weekly 50-minute sessions to discuss treatment planning and intervention strategies, which vary depending on the presenting problem of the client. Subsequent sessions follow the initial treatment plan, but routine follow-up assessments are scheduled for all clients. Presently, the PHQ and the CORE short form are administered after every four sessions to monitor progress and therapeutic outcomes. The counselor and client review these results and the information is recorded for formal evaluation of clinic effectiveness.

Evidence of Effectiveness
The Telehealth CAC (TCAC) has provided counseling to 81 women and 27 men since the program began in March 2009. Clients range in age from 9 years old to 73 with a mean age of 40.5 (SD = 14.1). Most identify as Caucasian. Major Depressive Disorder has been the most frequent single diagnosis (n = 59), followed by Panic Disorder (19), Post-traumatic Stress Disorder (18), and General Anxiety Disorder (11). Clients are seen an average of 11 sessions. The majority of clients are low-income, poor or indigent.

We have conducted two studies of clinical effectiveness. These are understandably difficult studies to conduct: Like any other community mental health setting (and unlike “laboratory” settings that often characterize academic research) clients cancel sessions, come late to sessions, terminate prematurely, and measures are not always completed as directed. Our research methods try to capitalize on the real-world data that our conditions permit. Preliminary data from the first 68 clients were encouraging. We found clinically significant improvements among clients after four sessions (McCord, Elliott, Wendel, Brossart, Cano, et al., 2011). As displayed in Figure 3, PHQ depression scores decreased significantly for men and women by an average of 5.88 points. Similarly, clients who completed the SF-12 measure reported important gains in their overall well being, as indicated by the Mental Health scale score and the Mental Health Composite score (see Figure 4).

Figure 3
Decreases in Client Depression after Four Sessions of Therapy via Videoconferencing to the Centerville Clinic

Note: From data reported in McCord et al., 2011.

A second study, now under editorial review compared group (nomothetic) and single-case (idiographic) analytic methods to analyze changes (Gonzales, Brossart, & Salerno, 2013). Of the 41 clients (34 women, 7 men) 83% met the criteria for Major Depressive Disorder and 75% of patients had two or more co-occurring disorders.

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Significant decreases on the PHQ depression scale are again seen among clients after four sessions. More than half of the clients (69%) evaluated after the fourth session demonstrated reliable improvements and another 23% were classified as recovered. Single-case analyses of seven clients (with varying diagnoses) indicated that five showed reliable change and three others experienced clinically significant decreases in depression. Improvements in their well-being (assessed by the SF-12 mental health scale) and personal adjustment (assessed by the CORE) were similar to the therapeutic gains reported by McCord et al. (2011). We found that 84% of the respondents were aware of our service. Only one reported they never referred a client to Telehealth and 25% reported they always referred LHRC clients to the TCAC (McCord, et al., 2011). Half of those who had referred to the TCAC were satisfied or very satisfied with the service, and one agency expressed dissatisfaction. Half of the respondents were very confident/confident that the services were, and only two sources stated not confident/a little confident.

Figure 4
Increases on Client Mental Health and Mental Health Composite Scores after Four Sessions of Therapy via Videoconferencing

![Graph showing mean scores on SF-12 scales before and after four sessions.]

Note: From data reported in McCord et al., 2011.

However, respondents were unaware that the TCAC staff offered other services, such as couples therapy and psychological assessments, suggesting that we can work to increase the awareness of the full range of services offered through the TCAC. Additionally, 81% of referral sources responding indicated that the TCAC probably or definitely increased access to psychological services, and all respondents indicated some level of agreement that services were more accessible to residents.

Training Benefits
Over this time period, the TCAC funded four different doctoral students with graduate assistantships to serve as half-time counselors (20 hours per week) and three others were supported for 10 hours per week. Ten other students worked with clients as part of their required practicum training. The practicum hours from the TCAC helps students prepare a competitive application to internship sites. It also gives them valuable experience in contemporary, long-distance technologies in providing psychological services that few other programs in the country can provide.

The TCAC also provides unique opportunities for our students to conduct outcome research and to present and publish their work. All of the studies to date have featured advanced students as lead and contributing authors. In particular, students are learning alternative methods to analyzing outcomes and obtaining evidence of effectiveness that may be more generalizable to real-life settings than the typical randomized clinical trial design. As the database for the clinic grows, we expect students to utilize more complex, contextual modeling procedures – that can accommodate missing data – to analyze therapeutic changes and outcomes over a longer time frame than previously reported.

Implications and Future Directions
Our ongoing research supports our unique “town and gown” partnership with community stakeholders, university resources, and a regional FQHC. This partnership resulted from improvements in the capacity of the community to collaborate, share information, seek assistance from external sources, and reach consensus on strategic solutions. In this process, the community maintains a sense of ownership and administration over the service. Supervising faculty members and doctoral students, for example, often attend community events to promote the TCAC and provide reports about the service to commission meetings. This kind of long-term investment and ownership is necessary to ensure adequate utilization of services, maintain a positive presence in the community, and define the ongoing commitments for local stakeholders – all of which are crucial for sustainability.

This project illustrates how community stakeholders can recognize and capitalize on the expertise of their partners – in the present case, the Counseling Psychology program, the CAC, and the CCHD – as important to their success in bringing an innovative solution for access to mental health services for their community. The mutual collaboration also exemplifies the potential doctoral programs may have in partnering with FQHCs and interdisciplinary endeavors in the community to enrich training while addressing disparities. The partnership provides the county with access to resources and expertise that they did not previously possess to build their capacity to address health issues in the community. In many ways, these activities typify the hallmarks of community psychology with the.
emphasis on building community capacity and maintaining mutually-beneficial collaborations.

Sustainability of the service remains a primary concern. To a great extent the TCAC differs from typical grant-funded projects because the HRSA funds were provided to create capacity to initiate and provide services. The project also differs from other initiatives from health care agencies because community stakeholders were involved from the beginning, and they were instrumental in identifying solutions. This kind of community engagement is often time-consuming, and it requires interdisciplinary collaboration to successfully cultivate a long-term investment and “buy in” from local stakeholders. Community engagement is essential for adequate utilization of services, for cultivating a positive presence in the community, and in securing ongoing commitments for local stakeholders – all of which are crucial for sustainability.

The TCAC has benefitted from the positive “press” Leon County officials have shared with their colleagues in surrounding counties. The CCHD recently assisted leaders in adjacent Madison County in obtaining an award from HRSA to support TCAC services in Madisonville. We will initiate services at a resource center in Madisonville later this spring. With generous support from the School of Rural Public Health at the TAMU Health Science Center we have relocated to new office space where we can utilize the high-speed TAMU T1 lines and pursue new lines of support that enable services to sites in Washington, Burleson and Grimes counties.

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A SERENDIPITOUS AFFAIR: How Many Made an Internship Consortium

Joseph McCoy, PhD, Edinburg, Texas
Shelly Blancett, Big Spring, Texas

On a hot summer’s day in 2008 in Austin, psychology students for Fielding Graduate University were assembled for a monthly meeting. The topic of late was the lack of psychology pre-doctoral internships in the state. Dr. Kimberly Thompson, then a graduate student, approached Shelley Blancett (now ABD) with her idea for facilitating the creation of internship sites, and the possibility of interning at the state hospital in Big Spring, Texas. “Big Spring?” said Ms. Blancett, “Where in Texas is Big Spring?” Little did they know that one of their supervisors, Dr. Ray Hawkins was very much involved with a group of people in Austin attempting to start a training consortium, which nearly came to pass. At the same time, the TPA membership had elected Dr. Ollie Seay as its president, and she was about to begin her tenure in January 2009. One of the many task forces she formed was the Internship Training Task Force to look into solutions for training shortages in Texas. She just happen to know a psychologist in South Texas who was offering a formal psychology internship training program out of his private practice, a gentleman (and we use the term loosely) of infamous heritage having the last name of McCoy. Ollie asked Ray and Joseph to join the task force, and Ray connected Ollie with the aforementioned graduate students who already had started networking with Dr. Melanie Gordon-Sheets, of Big Spring, and Dr. Jeffrey Wherry, of Lubbock, who then joined the task force. Thus, in February 2009, began the monthly task force phone conferences, which morphed into a consortium. All the while, Ray and Kimberly had been talking about the internship consortium created by the Arizona Psychological Association. Kimberly, having a penchant for writing papers overnight, took it upon herself to write a proposal of how such an organization might look in the state of Texas. The task force loved it and decided to give it the name The Lone Star Psychology Residency Consortium. Wasting no time, Dr. Larry “the Cable Guy” McCoy, registered the organization with the state and, via Ray Hawkins, we enlisted the help of the good folks at TANO (Texas Association of Nonprofit Organizations), and by summer of 2009 we were an official 501(c)(3) organization.

Since then, Shelley has become very familiar with Big Spring State Hospital (BSSH). It is one location of this growing multi-site consortium with the dual mission of providing psychological services to under-served populations and providing internships for Texas psychology students. She not only chose to stay in Big Spring after completing her internship, but also took on a leadership role in the continuation of the internship program there. We have to thank BSSH for being creative in its support of the internship by reallocating unfilled positions as there has been a state hiring freeze the entire existence of the consortium. This was a huge first step. The Lone Star Psychology Residency Consortium (LSPRC) was beginning to accomplish its mission by leveraging outstanding training opportunities available right here in Texas.

The first class of the Lone Star Consortium consisted of Shelley and Kim in Big Spring and Lubbock. Both spent the first half of the year working at Big Spring State Hospital, where they had ample opportunity to work with seriously mentally ill adults committed to the state hospital for both treatment and/or for forensic reasons. In addition, both had exposure to our veteran’s population through the contract BSSH has with the Veterans Administration. Kim also spent the second six months in Lubbock working with children in various settings with Dr. Jeffrey Wherry through the Institute for Child and Family Studies at Texas Tech University. Since then, funding shortages have not allowed Texas Tech to continue their participation in the Consortium.

They were soon joined by two interns and two postdocs working at Valley Psychological Services (VPS) in Edinburg. Didactic training modules were provided through the weekly teleconferences held via WebEx. The interns and the postdocs in the Rio Grande Valley were getting exposure to both private practice and inpatient consultation services provided to Doctors Hospital at Renaissance, a hospital campus that includes a behavioral unit, a women’s health unit, a med-surg unit and a rehabilitation unit.

Currently the LSPRC is focused on internships and is a member of an APPIC. As we have done with the two internship classes since then, we have two statewide meetings a year in Austin. At these meetings the interns get exposed to training from our contributing board members, as well as the opportunity to enjoy a richer amount of camaraderie than they get during the weekly WebEx meetings. We also end the year with mock oral examinations to help prepare them for licensure. Out of our first ten graduates one is fully licensed and three have their provisional licenses.

Though the Lone Star Consortium is a separate entity from TPA, the initial support from your state association was pivotal in the successful launch of this project. TPA still supports our efforts in many ways. Virtually all of our board
We would like to expand by helping other potential sites that do not have the resources to start an independent internship on their own. We have, and are in the process of creating a model, that works for the state of Texas that is somewhat modeled after the Arizona Training Consortium. Our other goal is to become APA accredited. By becoming an accredited consortium, the Lone Star Consortium will then be eligible to apply for HRSA grants and other federal monies that have been set aside to promote training opportunities. This will facilitate further expansion of internship opportunities for doctoral psychology students who continue to face the daunting task of applying for internships in a time when upwards of 22% of doctoral students do not find a placement. Last year that meant over 915 students were not placed in internships.

We are pleased to announce that Dr. Melanie Gordon-Sheets has assumed the position of our new Training Director. She will remain as the site director for Big Spring State Hospital. Dr. Joseph McCoy will continue as co-director of one of the Valley training sites along with our new co-director, Dr. Cynthia Cavazos-Gonzalez and Dr. Charles Walker co-director of the Tyler site. These people are automatically members of our board and are joined by Board President Dr. Ray Hawkins, secretary Dr. Brian Stagner, and Board of Directors: Dr. Paul Andrews, Shelley Blancett, MA (ABD/former LSPRC intern), Dr. Jerry Grammer, Dr. Michael Hand, Dr. Kelly Haynes-Mendez, Dr. Ollie Seay, and Dr. Jeff Wherry. The Lone Star Consortium needs your assistance in identifying potential member sites, board members and donations. We need board members with expertise in training interns, fundraising, and organizational development among other skill sets. We are in the process of developing an advisory board of public members who have a heart for the mental health needs of Texans, and who will assist with the very important and ongoing task of fundraising. If you cannot help us in any of the ways mentioned above just remember that no donation is too small, and it is tax deductible.

You can visit lsprc.wordpress.com and find the appropriate buttons to join our Constant Contact list and to make a donation.

Thanks for your interest in the Lone Star Consortium as evidenced by your reading this article.

At UTHSC Tyler, our interns will have opportunities to provide services along side medical residents, working in various collaborative care settings with primary care patients as well as specialty patients who have chronic disorders such as cystic fibrosis and cancer. Additionally, they will have the opportunity to work at the new ward that is an extension of Rusk State Hospital. They will do this under the direction of Dr. Charles Walker. We also give much thanks to Dr. Coultas, the Medical Director, for facilitating this development and allowing UTHSC Tyler to become our fiscal agent for the grant. We look forward to a long and fruitful relationship with UTHSC Tyler.

We also are proud to announce that, for the first time during our involvement with APPIC, we matched nearly all of our sites in Phase I of the match. And we just matched with our final intern in Phase II of the match on March 25.
Psychological Records: Update

Floyd L. Jennings, JD, PhD, ABPP

Overview
Though many psychologists view records with ambivalence (at best) and more negatively (at worst), other than a patient’s self-report, there is no reasonable means to provide an accounting of the psychologist’s diagnostic appraisal of a person, the design for a treatment plan, and the progress in implementation of such a plan. Records further serve the purpose of facilitating continuity of care by any other providers, as well as permitting adequate regulatory and administrative review. 22 TAC §465.22(2).

The Texas State Board of Examiners of Psychologists (TSBEP) recently updated the rules relating to records in 22 Tex. Admin. Code §465.22, changing the retention period. In the following brief note, however, I will review the rule in broad strokes and specifically point to the retention period.

Issues relating to records
Issues relating to records can be thought of in the following categories: (a) establishing records, (b) maintaining records, (c) retaining records, (d) disposing records, and (e) allowing access to or releasing records. However, there are multiple sections of the Rules that apply to records – relating to definitions (Rule §465.1), informed consent (Rule §465.11), confidentiality (Rule §465.12), tests (Rule §465.16), records (Rule §465.22), as well as disposition and assumption of a practice (Rule §465.32).

Establishing and maintaining records
What is a “record” and who “owns” it? The definition in Rule §465.1 is broad and essentially includes any information concerning a patient or recipient of services if not a patient (e.g. the subject of a forensic evaluation).

Who “owns” records? The patient? The clinician? Without digressing obscurely into property law, suffice it to say that medical records sui generis are a hybrid entity – created and maintained by the clinician who exercises all the functions of ownership, but with a virtual unfettered right of access (in Texas) by the subject of the records, namely the patient. The exceptions of such a right are few indeed and not the topic of this note – though technically it is possible for a clinician to deny the right of access by a patient, if such access would likely cause harm to the person. (This is not an exception upon which one would wish to rely. See Tex. Health & Safety Code §611.045).

Establishing and maintaining a record means deciding what is to be included, as well as what is not to be included, as well as the security of such records.

Records should include a written consent to treatment document executed by a person who is competent to do so – either the patient himself or herself, or a person permitted by law to exercise such consent as a parent in the case of unemancipated minors, or guardians of wards.

The record should contain sufficient information as to permit another provider both to ascertain the evaluation of the patient, the treatment plan and such progress which has, or has not, been made toward reaching the goals of such a plan.

Excluded is “test data.” Important in Rule §465.22(c)(3) is that test data are not part of a patient’s record and may not be released simply upon the receipt of a subpoena, but solely on consent or court order and then only to “another qualified mental health professional.” Test data means: “testing materials, test booklets, test forms, test protocols and answer sheets used in psychological testing to generate test results and test reports.”

HIPAA does apply in some respects, though the broad access by patients to their own record is far greater in Texas than would be permitted in HIPAA, among the aspects that apply are those appertaining to security of records. See 45 C.F.R. §164 Part A & C. In short, reasonable security arrangements should be established so that records are kept in a triple locked facility, e.g. an office suite, a file room, and locked file cabinet. Records are not to be left so as to be visible by authorized persons, etc. Reasonable protections of a patient’s privacy shall be established. The Rule also simply states that records must be stored in a fashion that permits review and duplication.

One final comment about maintaining records is that entries should be made as the rule says “timely” – in general terms, contiguous with the date of service rather than some period thereafter. Moreover, licensees are prohibited from “falsifying, altering, fabricating, or back-dating patient records and reports.”

Retaining records
For many years, all the mental health disciplines in Texas had different retention standards imposed by their boards, ranging from 5, 7 to 10 years, plus an equivalent number of years beyond the date of majority if the patient, when seen, was a minor.

TSBEP adopted a rule change effective March 8, 2013 under a 7/3 rule, i.e. seven years past the date of service, or three years past the age of majority. The text of Rule §465.22(d)(2) reads: “In the absence of applicable state and federal laws, rules and
regulations, records and test data shall be maintained for a minimum of seven years after termination of services with the client or subject of evaluation, or three years after a client or subject of evaluation reaches the age of majority, whichever is greater.”

Two scenarios illustrate the rule:
Scenario #1: A patient is seen while a minor, at age 7, upon parental consent. As the patient will reach majority at age 18, that record must be kept for 7 minus 18 years or 11 years –plus 3 years past the age of majority when the patient would be 21, and the record would be 14 years old.

Scenario #2: A patient is seen at age 17, upon parental consent, but will reach majority in only one year at age 18. The record must be kept for 7 years – or three years past the age of majority. As the longer period is 7 years, the record must be kept until the patient would be 24.

Note that the simple rule is to keep the record for 7 years or 3 years past the age of majority, whichever comes last.

Releasing records
Patients have a right of access to their own record by Rule and by statute, Tex. Health & Safety Code §611.045. A discussion of Chapt. 611 is beyond the scope of this note, but suffice it to say that there are numerous occasions in which a record can, or may, be released without the consent of the patient in judicial or administrative proceedings. From the point of view of the provider, however, information should be released either upon the consent of the patient or a court order. In most cases a subpoena is insufficient, absent consent.

Important viz. TSBEP, is that release of information pursuant to a valid consent or court order cannot be delayed, let us say for non-payment of fees, as there is a 15 day window during which such information must be made available. The provider holds no privilege (that is solely the province of the patient); and, as stated, the provider may not withhold information merely because payment for professional services is outstanding. See Rule §465.22(c)(7).

Disposition of records upon the death of the psychologist
TSBEP has proposed in the March 8th edition of the Texas Register to eliminate a portion of Rule §465.32 which has long been in place, namely the following section:

“[(4) A licensee shall make provisions for the transfer of his or her practice in the event of the licensee’s death or disability in compliance with this section, all applicable Board rules, and state and federal laws.] [(5) A non-licensee administrator or executor of a licensee’s estate should be encouraged to dispose of the licensee’s practice in accordance with this section.]”

This change in the Rule would be most welcomed because although there are realistically no penalties to be levied against a licensee after his/her death, many family members or executors have been burdened with disposition. It would nonetheless be proper to designate a recipient of one’s records, or to make provisions for appropriate destruction thereof.

Note that incapacity of a person, still a licensee, is a different matter and licensees should arrange for access in the event of incapacity whether temporary or permanent.

Summary
In this brief note I have reviewed the Rule concerning establishing, maintaining, releasing and disposing of records. The text of these rules can readily be found, at no cost, by following instructions on the TSBEP website, http://www.tsbep.state.tx.us/act-and-rules-of-the-board.

1 See, Mark A. Hall, JD; Kevin A. Schulman, MD, Ownership of Medical Information, JAMA. 2009;301(12):1282-1284
It’s not quite as momentous as, say a new version of the iPhone, but to judge from the broad coverage in the popular press over the past 18 months, the publication in May of DSM-5 may well change the course of civilization and the orbit of the planets, to say nothing of the bottom line of the American Psychiatric Association. You’ve doubtless read that the “Bible of Mental Health” is going to change.² There’s been a fair amount of controversy, and a larger measure of misinformation. The present article is both an overview of the process and a preview of the new order of things. Now that the drop date is upon us, we should review the rationale and process that led to these changes. This will conclude with a summary of the major changes that have caused some controversy.

The historical development of psychiatric nosologies can be understood as a sequence of clear, irreversible, conceptual improvements in classifying psychopathology. In the sixteenth century Johann Weyer contradicted the Church’s notion of that persons should be understood in contrast to a hypothetical paragon of the perfectly virtuous man that God intended us to be; he argued for description of individuals as they are observed to exist. In the nineteenth century Emil Kraepelin introduced the idea that members within a taxonomic class should have a uniform prognosis and outcome. After that, the diagnostic enterprise was stalled with disparate entities promoting their own systems (e.g. the Army, the Navy, the VA, and the APA³). The nosological quiescence that characterized the first half of the twentieth century was finally disrupted by the neo-Kraepelinian insistence that taxonomic categories become more reliable.

Reliability of DSM-II was mediocre at best and the neo-Kraepelinian movement set out to reassert the disease model of mental illness that had been neglected, if not disparaged, by voices such as Thomas Szasz, labeling theorists such as Thomas Scheff, and the hegemony of psychoanalysis asserting that we all needed to look for unconscious conflicts. DSM-III was based on the Research Diagnostic Criteria, a taxonomy that had been the first effort to create an empirically-based nosology for research purposes. DSM-IV and DSM-IV-TR followed this model and became the defining nosology for mental health in North America.

The Revision Process
In anticipation of the revision of the DSM-IV-TR, the process began in 1999 with preliminary conversations between representatives of the American Psychiatric Association and officials at NIMH. The APA in turn developed a Research Planning Conference to flesh out the research priorities. An effort was made to recruit “experts in family and twin studies, molecular genetics, basic and clinical neuroscience, cognitive and behavioral science, development throughout the life-span, and disability. To encourage thinking beyond the current DSM-IV framework, many participants closely involved in the development of DSM-IV were not included at this conference” (APA, 2012b). Thirteen subsequent conferences were held over several years to address specific research problems in the diagnostic literature, and these conferences produced a research agenda.

The DSM Task Force was established in 2006, funding was secured from several sources, and liaisons were established with the World Health Organization (WHO) and the World Psychiatric Association (WPA). The Task Force assembled work groups to study specific disorders as well as groups to investigate cross-cultural, gender, and age-related issues. The work groups each conducted extensive research projects on proposed revisions of the DSM-IV criteria; the results of these efforts have been published in psychiatric journals.

There has been a long chain of debates in the practitioner, research and patient advocacy communities about many of the proposed revisions. Concerns also have been raised about the overall structure of the manual and its overarching objectives. Some of these debates have been carried out in the lay press, and various constituent groups have weighed in with comments and objections. In addition there continue to be concerns about the process, including complaints about the composition of the Task Force itself.

Viewing the process in its historical context, Dr. Peter Nathan (who was a member of the DSM-IV revision task force) has noted that the DSM-IV group was assembled with a strong commitment to diversity — gender diversity, ethnic/cultural diversity, and diversity of professional input (Nathan, 2010). By contrast, the DSM-5 Task Force is much more exclusively representative of the medical model and less diverse in general. Questions have been raised, but without too much specific impact, regarding the influence of the pharmaceutical industry in the formulation of both the specific diagnostic criteria and in the overall biological orientation of the revised taxonomy.

When they approved the new DSM-5, the American Psychiatric Association Board of Trustees noted that the process involved the contributions of “more than 1,500 experts in psychiatry, psychology, social work, psychiatric nursing, pediatrics, neurology, and other related fields from 39 countries” (APA 2012a). It has indeed been a massive undertaking.
There are important reasons to revise DSM-IV – it’s not just an excuse to switch from Roman to Arabic numeration. The first big scientific step forward in the psychiatric taxonomy began in the early 1970s and culminated in 1980 with the publication of DSM-III. For the first time, explicit criteria were formulated to improve the reliability of each diagnostic category. In many instances these initial criteria had only limited supporting data. The two subsequent revisions (DSM-IV and DSM-IV-TR) incorporated new research to fine tune the accuracy of many criteria. These revisions yielded very impressive improvements in reliability, but “large-scale epidemiological studies have underscored the inefficiency of DSM’s criteria in accurately differentiating diagnostic syndromes, especially in community samples,” according to the leaders of the DSM-5 Task Force. They continue, “with the reification of the criteria through revised editions of DSM-III-R and DSM-IV, proliferation of diagnostic co-morbidities and over-reliance on the ‘not otherwise specified’ category has continued” (Kupfer and Regier, 2011).

The hope was that, by integrating the proliferation of neuroscience findings from the past decade, DSM-5 would be able to move beyond reliability to focus on improving the validity of the taxonomy by grouping disorders according to commonalities in presumed neurological and/or genetic causal substrate. The Task Force drew on the model of the Research Domain Criteria (RDoC) proposed by the National Institute of Mental Health (NIMH). The RDoC would reclassify disorders for research purposes into a neuroscience-based nosology grounded in basic pathophysiological similarities rather than phenomenological observations (Insel, et al., 2010). This effort to incorporate physiological etiological vectors (e.g. genetic risk factors) was not achievable: the necessary research base is not yet nailed down. However the effort will be made to include information on genetic, physiological, cultural and gender factors that predispose or potentiate a disorder and to describe the variability of clinical presentation across the lifespan. Whether there has been significant progress in this direction to justify this approach in the case of all disorders remains to be seen.

An Example: The Fate of Axis II
The effort to incorporate neuroscience findings is not controversial in itself. (What argument could be made to disregard the volcanic expansion of this body of research findings?) The problem is that the DSM is decided medical and relatively indifferent to the aspects of pathology that may be learned or may be products of environmental forces. This is most clearly evident in the way Axis II will be handled. Basically, the disorders on Axis II will be folded into the main body of disorders, but the APA has dropped the ball when it comes to incorporating recent research findings.

The problems with Axis II are notorious. The disorders are co-morbid within clusters, with the result that the probabilities have never been very good. Further, the personality disorders are very co-morbid with many disorders on Axis I. This goes to a larger issue—that of categorical vs. dimensional classification. When we think of, say, dependent personality disorder, are we dividing the population into the dependent and the nondependent or do we believe that individuals can be placed at some point along a dimension of dependent/nondependent? The need to create bright lines demarcating disorders is essential to further research agendas and it is often critical in developing treatment guidelines, but it is a poor way to incorporate the fact that personality traits have impact on virtually all aspects of human life. Personality traits contribute to life outcomes in medical well being, mental health, interpersonal relationships, and even mortality. The DSM-5 working group on personality disorders made a strong proposal to integrate personality features by incorporating a dimensional trait model that could be applied across the spectrum of clients, independent of their disorder. This represented a radical change but it was far from impetuous. A number of people worked to develop a data-based diagnostic process to implement this model. They developed a process with a high degree of reliability that would guide clinicians to make dimensional judgments about relevant personality attributes.

The researchers incorporated current knowledge about personality features and attempted to integrate it with existing empirical knowledge about psychopathology (Krueger and Eaton, 2010). This was a task that involved sophisticated psychometric modeling, and the team collected data on the relative merits of various algorithms for collecting and expressing personality trait information (Krueger, et al., 2011). The working group was coming to a consensus on a two-stage method for rating a patient on core personality traits and then rating the capacity for interpersonal functioning, two areas which will have important bearing on other aspects of medical and mental health (Hopwood, 2009). The pushback from the APA establishment was decisive. Even critics of DSM-5 such as Dr. Allen Frances (2012) mocked the use of trait ratings as too cumbersome (which may raise questions about medical education, but that is a different paper…). In the end, the DSM-5 Task Force voted to endorse the empirically-based procedures for incorporating trait and interpersonal information. Despite the strong backing of the DSM-5 Task Force and the working group on personality disorders (which included Dr. John Oldham, immediate past president of the American Psychiatric Association), the larger Board of Trustees of the APA voted, without presenting any evidence or discussion, to simply eliminate Axis II. At that point, the working group scholars who had devoted over five years of effort to the revision of the personality disorders declined further participation. The DSM-IV criteria for personality disorders will be folded into the main text.

It is difficult not to conclude that the Task Force is so enamored of finding the pathophysiology that they didn’t want to think about things like traits or the capacity for relatedness unless it fit their reductionistic agenda. As we know, reductionistic agendas lead to reductionistic treatments and many observers are concerned that all this may benefit Big Pharma more than it will benefit the patients.

Stigma, Reliability and Validity
The general process also has revived many familiar concerns about labeling and stigmatizing in the diagnosis of mental illness. Thus criticism from feminist therapist associations
emphasized the ways in which they feel certain diagnoses have been applied or misapplied to the disadvantage of women whose problems might be better understood as the result of social inequities or economic pressures. These critiques echo points made by Thomas Scheff (1999) and others. The current scholarly version of this controversy emerges from the stretching of diagnostic bandwidth within diagnostic categories. In forensic settings there is concern that discrete categories are subtly broadened to make scientifically unsupportable claims that may either exculpate or condemn individuals whose behavior is probably not truly pathological in origin (e.g., Gopal & Bursztajn, 2007). Critics too numerous to catalog have noted that bipolar disorder (especially among children) and ADHD diagnoses have become astonishingly more frequent over the past fifteen years, and some have alleged a sort of mission creep in diagnoses. Jerome Wakefield and Alan Horowitz have written extensively on the error of expanding the diagnostic bandwidth for depression to the extent that one is no longer permitted to experience ordinary sadness without the opportunity for treatment (Horowitz & Wakefield, 2007).

These and other concerns led to a petition (evidently originating in the American Psychological Association’s Division 32—Humanistic Psychology) calling on policymakers, clinicians, researchers, and the pharmaceutical industry to avoid the use of DSM-5. The petition notes that the DSM-5 Task Force has failed to provide a clear definition of a mental disorder, despite the lofty aspirations that were articulated at the outset. The statement notes that, while the DSM-5 revision has involved hard work by many leading scientists, the final product has not been subjected to an independent scientific review. Concerns are expressed about the lowering of diagnostic standards and the introduction of new diagnostic categories. The statement notes that the field trials were intended to examine first reliability and then to look at quality control, but the second phase was cancelled due to time pressures. Supporters of the petition argue that, under DSM-5:

- Many individuals will receive diagnoses who might fare better without a diagnosis.
- Some individuals may result in unnecessary or harmful treatment.
- Resources may be diverted away from the areas of greatest need.

These arguments are not only ideological; they pivot around central psychometric principles. To the extent that classification is conducted with precision, the information contained in a diagnosis may outweigh the potential damage of stigmatizing labels. This goes to reliability and validity questions. DSM-III produced improvements in reliability; DSM-5 criteria were intended to address validity concerns. However data presented at a recent meeting of the APA raise some thorny questions. Part of the revision process involved extensive field trials conducted on whether clinicians would use the proposed criteria consistently. This yields a kappa statistic, which reflects inter-rater agreement after correcting for chance. Kappas above 0.5 are pretty good: 70% agreement between two people is equivalent to a kappa value of 0.4.

The field trial results have been mixed. For some disorders (e.g., major neurocognitive disorder, PTSD, autism spectrum disorders) kappas ranged between 0.67 and 0.78. On the other hand, many common disorders (including generalized anxiety disorder and major depressive disorder) the kappas were low—in the 0.20 to 0.40 range. Taken as a whole the DSM-5 field trials produced kappas that are equivalent to inter-clinician agreement of only 50% (Ghaemi, 2012). While these numbers are not dissimilar to the numbers produced in other (nonpsychiatric) medical settings, it has been observed that some of the kappa values in the DSM-III were higher than those produced with DSM-5 criteria for the same disorder.

Choose Your Paradigm
For all the hoopla and huge expense, the DSM-5 is certainly not the major paradigm shift that its creators had envisioned it would be a decade or more ago. Rather, it is an incremental step forward, tweaking things here and there and adding some ingredients to the mix. It may prove more useful for researchers, insofar as some definitions are tightened up, but these improvements are not game changers. The hoped-for integration of pathophysiological etiologies, reductionistic diagnostic tools and ideographically targeted treatments awaits further research.

Once they adapt to the changes, clinicians may find DSM-5 is easier, better, more useful. Further research may demonstrate that it shows better overall kappa values than the field trials established. On the other hand, the DSM system may have little day-to-day impact on the practitioner. Former American Psychological Association President and TPA President-Elect Designate Dr. James Bray noted:

> APA Board of Directors and Council of Representatives voted in 2009 to support the work of a psychologist, to work on the WHO’s next version of the International Classification of Disease (ICD) (http://www.who.int/classifications/icd/en/). The ICD is the only system used in the general health care arena and in fact DSM diagnoses are converted to ICD diagnostic codes by insurers during the reimbursement process. With the implementation of the Accountable Care Act in the U.S. health reform process, only the ICD will be used in the future. This is why it was so timely for the APA to be involved in the next version of the ICD system. There will be sessions and updates on the ICD revision at the APA convention, and I encourage you to attend those and start using the ICD in your work. Over time the DSM will in all likelihood be eliminated in health care diagnosis. (2012)

The strength of the World Health Organization’s (WHO) International Classification of Diseases ICD-10 (and ICD-11, which is coming soon), is that it permits swift communication with global health organizations, including the WHO. The disadvantage, of course, is that the ICD lacks the extensive research base that supports the DSM system.

General Changes
Previous revisions of the taxonomy resulted in major changes in the number of categories. DSM-II had 186 diagnostic categories. DSM-III had 265, and DSM-IV had 365. For the first time in the history of DSM revisions, the next revision will not substantially change the number of categories. The organization of the book will be somewhat different, however.
The volume will be divided into three broad sections. Section 1 will introduce the DSM-5, and provide “information about how to use the manual” (APA 2012). It is not entirely clear what that phrase will mean.

The organization of the chapters will be revised to locate chapters in such a way that disorders that seem related to one another are in adjacent places in the manual. As noted above, the apparent relatedness seems to be based on either having similar symptom profiles or similar causal predispositions—pathophysiological commonalities. The reorganization of the chapters will bring DSM-5 into more consistent alignment with the eleventh edition of the ICD-11. Notably, it is expected that, one day in the future, the United States will officially adopt the ICD-11, although, we are often late to come into compliance with what the rest of the world is using. Standardization will greatly enhance the global sharing of research findings and presumably translate into better scientific grounding for diagnosis and treatment.

The other general change will involve dropping the multi-axial system. There appears to have been very little discussion or debate about this change. No data were presented to justify this change, nor is the rationale very well-defined. The change may or may not turn out to be a good idea; the process itself has been abrupt and imperious. The information that was heretofore contained in Axis I, II, and III will now all go into Section 2 and provision will be made to make notations about any psychosocial factors that are relevant (the information coded on Axis IV in the prior DSMs) and about any contextual information (previously this was captured in the GAF score on Axis V). This may be a housekeeping change, but it also has the potential to alter clinician’s behavior in significant ways. Which way it goes will depend on the nature of the provisions for these notations.

Section 2: Specific Disorders

Debate on the merits of DSM-5 will continue. In the meantime, it is intended that DSM-5 will be a tool for clinicians in active practice. Below is a summary of changes that are anticipated in several categories. The list is not exhaustive but meant to highlight general revisions to the nosology. You have to shell out nearly $200 to the AMA to get the whole story, if you need it. You may wish to identify those disorders that you encounter most frequently and search for the new criteria online (in the publications that describe the field trials for different diagnoses or other sources).

Anxiety Disorders. While there do not seem to be major changes to definitional criteria here, the various disorders will be reorganized.

- Post-Traumatic Stress Disorder will be in a group of trauma and stress-related disorders, not in the anxiety disorders.
- Several disorders will be grouped with Obsessive-Compulsive Disorders including Body Dysmorphic Disorder and Trichotillomania.
- Hypochondriasis will be renamed as Illness Anxiety Disorder.

Autism Spectrum Disorder. There has been a good deal of controversy in this area. Several categories that were separate in DSM-IV, including autistic disorder, Asperger’s disorder, childhood disintegrative disorder, and pervasive developmental disorder (NOS), are now collapsed into a single disorder. This proposal was grounded in research data that seems to indicate that these several syndromes all have a common pathophysiological basis. There was a good deal of alarm from several stakeholder groups. The DSM Task Force has tried to refine the wording of the criteria to provide diagnosticians with more clear-cut examples of the clinical presentation of these disorders. Concerns remain about the stigmatizing effects of this change on higher function patients in this spectrum.

Binge-Eating Disorder. This has been listed in Appendix B in DSM-IV, which includes issues needing further research. It will be moved to Section 2 (the main listing of established disorders). This is in recognition of the growing body of research on this problem and will facilitate access to treatment for these patients.

Dementia is replaced by Major Neurocognitive Disorder and Mild Neurocognitive Disorder.

Disruptive Mood Dysregulation Disorder. In an effort to address concerns about over-diagnosis of bipolar disorder in children, this category will include children who have persistent irritability and/or explosive outbursts several times per week.

Excoriation Disorder. The DSM-5 will include this specific category for skin-picking under Obsessive-Compulsive and Related Disorders (OCD).

Hoarding Disorder. This new category is supported by extensive research data, which link it as a separate category under the OCD group. The criteria will specify that the hoarding involves inability to part with items that have little value and a degree of impairment that has harmful social, emotional, physical or financial impact for the hoarder and/or the family of the afflicted person.

Pedophilic Disorder will be the new name for pedophilia. Despite some controversies in the sex offender literature, the criteria will be unaltered.

Personality Disorders. There was a great deal of hope for this revision. They lose their own axis. Otherwise nothing changes.

Premenstrual Dysphoric Disorder will be moved from the “Research” section of DSM-IV (Appendix B) to the affective disorder section in DSM-5.

Removing the Bereavement Exclusion. In DSM-IV, persons experiencing depressive symptoms secondary to bereavement were excluded from a diagnosis of affective disorder if the symptoms had lasted less than two months. The DSM-5 revision drops this exclusion and substitutes information defining and distinguishing the differences between grief and depression. According to the DSM-5 Task Force “this reflects the recognition that bereavement is a severe psychosocial stressor that can precipitate a major depressive episode beginning soon after the loss of a loved one (APA, 2012). This
has been a very controversial change, which will likely be subject to further debate.

**Specific Learning Disorders** are somewhat broadened from the DSM-IV criteria, and there will be effort to accommodate distinct disorders involving oral language, reading, mathematics, or written language.

**Sex and Gender Problems.** There will be name changes. Premature Ejaculation becomes Early Ejaculation; Male Orgasmic Disorder becomes Delayed Ejaculation, and the categories of Female Hyperactive Sexual Desire Disorder and Female Sexual Arousal Disorder will be combined under Female Sexual Interest/Arousal Disorder. Gender Identity Disorder will become Gender Dysphoria.

**Substance Use Disorder** will be a single disorder which combines the DSM-IV categories of substance abuse and substance dependence. This was a distinction that was somewhat squishy in the field. The new disorder is a stronger diagnosis: previous criteria called for only one symptom while DSM-5’s “mild” substance abuse disorder insists on two to three symptoms.

**Section 3: Didn’t make the cut**
As noted above, the effort to push the APA to recognize the impact of personality traits on mental and physical well-being was quashed. Instead it was relegated to Section 3, implying that further research would be necessary to warrant inclusion of personality trait information in the diagnostic enterprise. It has interesting company there. Several disorders have been proposed and debated that will not find their way into section two. Some of these have a promising research base, but in the judgment of the working groups there is not enough certainty to warrant inclusion. Among the disorders that will be included in Section 3 are:

**Attenuated Psychosis Syndrome.** Depending on one’s perspective, this may be either the scariest specter of Big Psychiatry Taking Over on Behalf of “Them” or else it is one of the most exciting, game-changing developments in the neuroscience of schizophrenia. The emerging data from neuroimaging studies suggest that (1) the earlier pharmacological treatment can be initiated the more successfully the deterioration of the schizophrenic patient will be contained and (2) it is now possible to use neuroimaging to detect incipient psychosis before the first schizophrenic break is manifested in overt symptoms. There are calls for preventive intervention with young people who seem to be at risk for psychosis. The concern is that prescribing powerful antipsychotic medications to adolescents who are not yet showing active psychosis should not happen until we have a much better understanding of the neuroscience.

**Non-Suicidal Self Injury.** A growing body of evidence suggests that this behavior is orthogonal to the conditions with which it has been associated. It often occurs independently from suicidal intent and is not as perfectly correlated with personality disorder as once thought. It may be an independent disorder unto itself, but underlying pathophysiology has not been clearly identified. Suicidal Behavior Disorder. This may turn out to be a variant of non-suicidal self injury, or it may turn out to be a relatively independent syndrome.

**Internet Use Gaming Disorder.** Although parental support is overwhelming, and while there is some research support for this disorder, the science is simply not there yet.

It is anticipated that some of these disorders will eventually be folded into Section 2 when the research base is more firmly established. Several other disorders were proposed that were not included for either Section 2 or Section 3. These seem to be disorders for which there may be theoretical support, but which lack sufficient empirical foundation to encourage their inclusion. Among these are: Anxious Depression, Hypersexual Disorder, Parental Alienation Syndrome and Sensory Processing Disorder.

**In Conclusion**
The DSM-5 is the product of an enormous amount of work, all of which has been boiled down in a way that mostly preserves the status quo ante. There are a number of substantive changes and some nomenclature shifts, but these are relatively few and will not be too disruptive for the clinician in the trenches. Despite the aspirations of the APA to dramatically improve the integration of pathophysiological modeling, this effort seems (from the available descriptions) to have fallen short. Nevertheless, the groundwork has been laid out to move toward a more reductionistic, less psychological taxonomy. Future rolling amendments (e.g. DSM-5.1, 5.2, etc.) will be built on this base.

How concerned should psychologists be? In the short run we will all need to be fluent with the new jargon, as well as getting ready for the impact of the ICD in coming years. There are more immediate threats on the horizon. Declining reimbursements, the coming need to document outcomes for Medicare, the quality controls that will be imposed by the Affordable Care Act, the definition of “physician”, and the ever-present SGR cuts all besiege us at the national level. The threats in Texas include cuts to services to our patients and the biannual threats to our profession that we face at the legislature.

In the longer term, however, DSM-5 may define the larger battleground for psychology as a profession and as an intellectual discipline.

**Notes**
1Texas Psychological Association, Director of Professional Affairs

2I’m not sure whether to object to this appellation more on behalf of faith or on behalf of science.

3There are, of course, several options for the “P” in APA (Psychological, Psychiatric, Philosophical, perhaps Plumber? Pistachio?). The present article concerns a manual produced by the Psychiatric APA, and all references to APA herein shall refer to this organization unless otherwise noted.

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